Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004168	A. BUILDING _____ B. WING _____	05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD CROSSING APARTMENTS	1212 WATERFORD CIRCLE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 23-25, 2011 Facility number: 004168 Provider number: 004168 AIM number: N/A Survey team: Honey Kuhn, RN TC Carol Miller, RN Census bed type: Residential: 34 Total: 34 Census payor type: Other: 34 Total: 34 Sample: 7 Waterford Crossing Apartments was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review completed on May 25, 2011 by Bev Faulkner, RN	R 000		